STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155729	A. BUILDING 00 B. WING	08/21/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ADAMS HERITAGE	12011 WHITTERN RD MONROEVILLE, IN 46773

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F 0000 Bldg. 00	This visit was for a Recertification and State Licensure Survey. Survey dates: August 17, 18, 19, 20, & 21, 2015 Facility number: 002549 Provider number: 155729 AIM number: 200289420 Census bed type: SNF/NF: 47 Total: 47 Census payor type: Medicare: 4 Medicaid: 29 Other: 14 Total: 47 These deficiencies reflect state findings cited in accordance with 410 IAC 16.2-3.1.	F 0000	Preparation and execution of this plan of correction does not constitute admission or agreement by provider to the truth of the facts alleged or the conclusions set forth in the Statement of Deficiencies rendered by the reviewing agency. The Plan of Correction is prepared and executed solely because it is required by the provisions of federal and state law. adams-Heritage maintains that the alleged deficiencies do not individually or collectively jeopardize the health and/or the safety of its residents nor are they of such character as to limit the provider's capacity to render adequate resident care. Furthermore, adams-Heritage asserts that it is in substantial compliance with regulations governing the operation of long term care facilities, and this Plan of Correction in its entirety constitutes this provider's allegation of compliance and, thereby, we request resurvey to verify such as of August 28, 2015. **Further, we request desk review (paper compliance) for compliance, if acceptable.** Completion dates are provided for procedural processing purposes to comply with federal and state regulations, and correlate with the most recent contemplated accomplished corrective action.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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			These do not necessarily chronologically correspond to the date that Adams Heritage is under the opinion that it was in compliance with the requirements of participation or that corrective action was necessary.	
F 0329 SS=D Bldg. 00	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. Based on interview and record review, the facility failed to attempt a gradual dose reduction for a psychotropic medication for 1 resident (Resident #37) of 5 residents reviewed for unnecessary	F 0329	F329 1. Describe what the facility did to correct the deficient practice for each client cited in the deficiency. Resident #37 remains on Risperidone 0.25mg daily at HS and remains stable	09/15/2015

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	medication. Findings include: Review of the clinical record for Resident #37 on 8/18/15 at 2:28 p.m., indicated the following: diagnoses included, but were not limited to, Alzheimer's disease, dementia with behavioral disturbances, generalized anxiety disorder, and insomnia. A Psychiatry Note for Resident #37, dated 6/11/14, indicated she had been diagnosed with Alzheimer's disease and suffered from confusion, anxiety, and personality change. The note also indicated there was no depression, no euphoria, no emotional lability, no hostility, not suicidal, no compulsive behavior, no impulsive behavior, no unusual behavior, no violent behavior, no disturbing or unusual thoughts, feelings, or sensation, no unreasonable or irrational fears, no magical thinking, not having fantasies, no interpersonal relationship problems, no emotional problem/concerns, no sleep disturbances, normal functioning ability, and no character deficiency. The note further indicated she exhibited hallucinations, but exhibited no delusions. The note indicated the plan to start Risperidone (anti-psychotic medication) 0.25 mg		without symptoms. The physician's order states that dose reduction is medically contraindicated. The attending physician was contacted on 9/15/15 for a dose reduction order as a result of this finding. 2. Describe how the facility reviewed all clients in the facility that could be affected by the same deficient practice, and state, what actions the facility took to correct the deficient practice for any client the facility identified as being affected. Other residents with the propensity to be affected by the same alleged deficient practice would be identified as those residents on Risperidone. None were identified. 3. Describe the steps or systemic changes the facility has made or will make to ensure that the deficient practice does not recur, including any in-services, but this also include any system changes you made. The DON(designee) will audit those residents on Risperidone to assure that they have care planned a GDR if NOT medically contraindicated. 4. Describe how the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place. Monthly behaviors meetings will be held including Pharmicist, Administrator, D.O.N., Social Service Director, Floor Nurse, and Physician. GDR for residents on Risperidone if any will be reported by D.O.N. at	

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	(milligrams) daily at HS (hour of sleep). A Psychiatric Follow-up Note for Resident #37, dated 6/25/14, indicated the current diagnoses of Alzheimer's disease, generalized anxiety disorder, dementia, and senile dementia with delusional features. The note recommended to continue Risperidone 0.25 mg HS. A Psychotropic Medication Meeting note for Resident #37, dated 6/17/15, indicated her behaviors and moods were stable. The note also indicated to not adjust her medication. A physician's order for Resident #37, dated 6/25/14, indicated Risperdal 0.25 mg HS for delusional thinking. A Social Service Note for Resident #37, dated 9/12/14, indicated her diagnoses included senile dementia with delusional disorder, Alzheimer's disease, generalized anxiety disorder, and insomnia. The note also indicated her medications included Risperdal. The note further indicated there were no negative behaviors cited by staff. An Adverse Behaviors/Moods/Interventions note for Resident #37, dated 9/17/14, indicated		monthly QA/PI.	

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	she was stable, her behaviors had decreased substantially, and not to adjust her medications. A Social Service Note for Resident #37, dated 12/4/14, indicated she continued to receive Risperdal. The note also indicated there were no behaviors noted. An Adverse Behaviors/Moods/Interventions for Resident #37, dated 12/17/14, indicated she displayed disorganized speech, inattention, and trouble concentrating on 12/17/14. The Recommendations/Notes indicated to not adjust her medications (contraindicated statement from MD and family/POA). There was no documentation in the clinical record of a physician contraindication statement. A Note to Attending Physician/Prescriber from the Pharmacy for Resident #37, dated for the month of December 2014, indicated she was receiving Risperdal 25 mg HS and the Risperdal was due for a GDR (gradual dose reduction). The note also indicated per discussion with the behavior management team, the resident continued to exhibit behaviors and a reduction did not seem to be in her best interest. The note further indicated Resident #37's physician agreed. There was no additional documentation or			

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	tracking of behaviors or symptoms in the clinical record, and no documentation in the clinical record of a physician contraindication statement. A Physician visit note for Resident #37, dated 2/20/15, indicated the Risperdal would not be changed per pharmacy recommendation. A Social Service Note for Resident #37, dated 5/20/15, indicated she continued to receive Risperdal. The note also indicated there were no negative behaviors noted. A Psychotropic Medication Meeting note for Resident #37, dated 6/17/15, indicated her behaviors and mood were stable and to not adjust her medications. A physician's order for Resident #37, dated 7/2/15, indicated Risperdal 0.25 mg HS for dementia with delusions. A Nursing Note for Resident #37, dated 7/2/15, indicated to change diagnosis of Risperdal to dementia with delusions. A Note to Attending Physician/Prescriber from the Pharmacy for Resident #37, dated 7/15/15, indicated she was receiving Risperdal 0.25 mg for dementia with behaviors and the Risperdal was due			

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	for a GDR. A handwritten note from the Director of Nursing on the GDR request from the pharmacy, dated 7/20/15, indicated she was under the care of a Psychiatrist and the facility had a contraindication statement for the resident. There was no documentation the resident had seen a psychiatrist since 6/11/14, no documentation or tracking of behaviors or symptoms in the clinical record, and no documentation in the clinical record of a physician contraindication statement. Review of the Nursing Notes for Resident #37, dated 7/31/15 through 8/20/15, only indicated 1 episode of delusional thinking on 8/11/15. Review of Resident Care Meeting Notes, dated from 8/22/14 through 8/3/15, did not indicate Resident #37 displayed any adverse behaviors or moods. A Resident Care Guide for Resident #37, with a start date of 5/8/14, indicated she could become confused, lost, agitated at times, combative, and argumentative. The guide also indicated she could be redirected. The guide did not include the symptom of delusions. A statement from Resident #37's physician, dated 8/20/15, indicated "It is			

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	has been in the past and is now also clinically contraindicated to attempt reduction of this medication. Resident is on the lowest possible dose to address her condition (recommended dose for geriatric patients is 0.5 mg daily - bid (twice a day); patient is only on 0.25 mg Q (every) HS daily. Reducing or discontinuing this medication would severely impair the resident's function and increase distressed behavior. Reducing this medication would also likely increase the instability of her known psychiatric diagnosis." A copied page from Mosby's 2014 Nursing Drug Reference, provided by the Director of Nursing (DON) on 8/20/15 at 11:45 a.m., indicated a Black Box Warning for Risperidone with increased mortality in elderly patients with dementia-related psychosis. A facility care plan for Resident #37, with a review date of 5/27/15, indicated the problem area of diagnosis of Alzheimer's disease and senile dementia with delusional features - at risk for impaired cognitive function, changes in moor/behavior, and /or changes in psychosocial well being due to disease process, alteration in mood related to anxiety disorder. Approaches to the problem included, but were not limited			

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	to, administer medications as ordered, keep physician updated, observe for adverse moods and/or behaviors and document, attempt to identify environmental triggers, medical condition, or other factors that may be causing adverse issues and attempt to resolve, and provide guidance, supervision, and cues as needed to maintain health and safety. The Director of Social Service was interviewed on 8/19/15 at 1:45 p.m. During the interview she indicated any behaviors a resident may exhibit were to be documented in the nursing notes. She also indicated during each morning meeting, the DON would print off any nursing notes of the residents who had exhibited behaviors for discussion. She further indicated the nursing notes printed off by the DON were how she received the information concerning behaviors of residents. She also indicated Resident #37 was not seen by the Psychiatrist on a regular basis, but only once per year. A family member of Resident #37 was interviewed with the DON on 8/20/15 at 9:15 a.m. During the interview he indicated when Resident #37 was admitted to the facility she would yell, pace, and cry. He also indicated her			

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	physician tried her on numerous medications and the Psychiatrist had placed her on Risperdal. He further indicated after she was started on the Risperdal, a nurse from the facility contacted him telling him the medication was not appropriate for individuals diagnosed with Alzheimer's disease, but a few days later the nurse called him again and informed him her behaviors were better. The DON and Administrator were interviewed on 8/20/15 at 3:00 p.m. During the interview they indicated Resident #37 had done well on the Risperdal and they would work hard to keep her on it. They also indicated she had continued to have behaviors, but they were not documented. They did not indicate she had displayed any delusional behaviors. A current facility policy "Anti-Psychotic Drugs", with a revision dated of 10/11 and provided by the Director of Social Services on 8/20/15 at 11:55 a.m., indicated "...The physician in coordination with the Behavior Management team will continually re-evaluate the need for the drug and suggest "drug holidays" or reduction of dosage to the lowest possible dose to control symptoms...."			

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	3.1-48(a)(2)			
F 0371 SS=E Bldg. 00	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions Based on observation, interview and record review, the facility failed to ensure staff washed their hands for the recommended amount of time, after touching residents and soiled objects, and before assisting residents with their meals and feeding residents their meals. The	F 0371	F371 PART A – Pantry 1. Describe what the facility did to correct the deficient practice for each client cited in the deficiency. The resident/pantry refrigerator was cleaned on Friday, August 21, 2015. All food items without names/dates were removed from the pantry	09/03/2015

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	facility also failed to protect clean clothing protectors from potential contamination. The facility further failed to ensure foods kept in the pantry freezer/refrigerator were properly labeled and dated and the refrigerator was clean and free of spills. This deficient practice had the potential to affect 46 of 47 residents who received food and beverages prepared, served, and stored by the facility. Findings include: 1. During an observation of the lunch meal in the dining room on 8/17/15, the following was observed: At 11:11 a.m., Certified Nursing Assistant (CNA) #1 was observed to lather her hands for 14 seconds prior to rinsing. She was then observed to sit down next to residents seated at a dining room table. At 11:13 a.m., CNA #2 was observed to lather her hands for 9 seconds prior to rinsing. She was then observed to assist with meal service. At 11:15 a.m., CNA #2 was observed to lather her hands for 4 seconds prior to rinsing. She was observed to move a resident seated in a geri-chair closer to a		refrigerator. No residents were harmed by this alleged deficient practice. 2. Describe how the facility reviewed all clients in the facility that could be affected by the same deficient practice, and state, what actions the facility took to correct the deficient practice for any client the facility identified as being affected. Staff of Adams Heritage was re-educated that the pantry refrigerator is for resident use. All items must be dated and labeled with the resident's name prior to placing in the pantry refrigerator. 3. Describe the steps or systemic changes the facility has made or will make to ensure that the deficient practice does not recur, including any in-services, but this also include any system changes you made. The pantry refrigerator will be cleaned and monitored by the Dietary Department. The cleaning/monitoring of the pantry refrigerator will be documented at least daily by the dietary department. This will occur on a daily basis effective 9/1/15. 4. Describe how the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place. The pantry cleaning record will be reviewed daily by the Dietary Manager/designee. Results of the monitoring will be reported to the QA/PI committee.	

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	dining room table and also move a small stool on wheels with her bare hands next to a resident seated at a dining room table. She was then observed to leave the dining room. At 11:16 a.m., CNA #1 was observed to get up from the table where she was seated, move to the handwashing sink, and lather her hands for 11 seconds prior to rinsing. She was then observed to sit down next to residents seated at a dining room table. At 11:18 a.m., CNA #2 was observed to re-enter the dining room. She was observed to lather her hands for 6 seconds prior to rinsing. She was then observed to sit down next to a resident seated at a dining room table. At 11:20 a.m., CNA #2 was observed to leave the dining room. At 11:23 a.m., CNA #2 was observed to push a resident seated in a wheelchair into the dining room and up to a dining room table. She was observed to pick up a clean clothing protector and place it on the resident without washing her hands. At 11:24 a.m., CNA #2 was observed to lather her hands for 7 seconds prior to rinsing. She was then observed to sit		PART B – Hand washing 1. Describe what the facility did to correct the deficient practice for each client cited in the deficiency. No residents were harmed by this alleged deficient practice. An in-service was held to review and re-educate certified nursing assistant regarding hand washing. In-service was completed on 8/27/15. A clock was placed on 9/3/15 by the dining room hand washing sink to enhance visualization of 20 seconds. Hand sanitizer was obtained for each employee for use in between resident assistance. This was completed on 9/3/15. 2. Describe how the facility reviewed all clients in the facility that could be affected by the same deficient practice, and state, what actions the facility took to correct the deficient practice for any client the facility identified as being affected. Residents in need of feeding assistance were moved to two tables by the hand washing area. This action was part of an established QA/PI program to enhance dining experience for those with feeding assistance needs. This was completed on 9/1/15. 3. Describe the steps or systemic changes the facility has made or will make to ensure that the deficient practice does not recur, including any in-services, but this also include any system changes you made. Staff hand washing in the dining	

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	down next to a resident seated at a dining room table. At 11:25 a.m., CNA #2 was observed to get up from the dining room table where she was seated and close the window blinds. She was then observed to lather her hands for 12 seconds prior to rinsing and return to the same dining room table. At 11:26 a.m., CNA #1, who was still seated next to a resident at a dining room table, picked up the resident's eating utensils and prepared the food for her to eat. She was not observed to wash her hands prior to handling the eating utensils. At 11:27 a.m., CNA #1 was observed to get up from the dining room table where she had been seated, move to the handwashing sink, and lather her hands for 11 seconds prior to rinsing. She was then observed to return to the dining room table, pick up the eating utensils for a resident, feed the resident the lunch meal, and move glasses of beverages around the table by touching the rims of the glasses. At 11:31 a.m., CNA #2 was observed to leave the dining room At 11:37 a.m., CNA #2 was observed to		room will be monitored daily times five days at rotating meals, then weekly for four weeks, then quarterly thereafter by the Director of Nursing/Designee. Started on 9/3/15. 4. Describe how the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place. Results of the monitoring will be presented to the monthly QA/PI meeting. This practice will be quarterly monitored throughout the year.	

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	155729	A. BUILDING 00 B. WING	08/21/2015

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ADAMS HERITAGE	12011 WHITTERN RD MONROEVILLE, IN 46773

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	re-enter the dining room. She was observed to lather her hands for 14 seconds prior to rinsing. She was then observed to sit at a table next to a resident, pick up the resident's eating utensils, and begin to feed the resident the lunch meal. At 11:39 a.m., CNA #2 was observed to remove a resident from the dining room. At 11:43 a.m., CNA #2 was observed to re-enter the dining room. She was observed to lather her hands for 11 seconds prior to rinsing. She was then observed to sit at a table next to a resident seated at a dining room table and assist the resident with the lunch meal. At 11:45 a.m., CNA #1 was observed to get up from the dining room table where she had been seated. She was observed to move to the handwashing sink and lather her hands for 7 seconds prior to rinsing. She then returned to the dining room table, picked up the resident's knife and fork, and cut up her food for her to eat. At 11:47 a.m., CNA #2 was observed to stand up from the table where she had been seated. She was observed to rest her right hand on the back of a resident's geri-chair. She was then observed to sit			

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	down by pulling her slacks up with her hands and continued assisting residents with their lunch meal. She was not observed to wash her hands after touching soiled objects. At 11:48 a.m., CNA #1 was observed to get up from the table where she had been seated, move to the handwashing sink, and lather her hands for 8 seconds prior to rinsing. She was observed to return to the same dining room table, assist a resident with the lunch meal and feed another resident the lunch meal. At 11:50 a.m., CNA #2 was observed to remove menus from several dining room tables and clear dirty dishes from a place setting at a dining room table. She was then observed to leave the dining room. At 11:51 a.m., CNA #2 was observed to re-enter the dining room. She was observed to lather her hands for 15 seconds prior to rinsing. She was then observed to sit at a dining room table and feed a resident the lunch meal. 2. During an observation of the facility pantry on 8/17/15 at 12:03 p.m., the following was observed: In the freezer section of the refrigerator in the facility pantry, there were 3			

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	microwaveable meals not labeled or dated and a paper sack containing homemade ice cream sandwiches not labeled or dated. In the refrigerator in the facility pantry, there was a large spill of a dried sticky substance underneath the vegetable bins. The floor of the pantry was sticky. 3. During an observation of the lunch meal in the dining room on 8/19/15, the following was observed: At 11:41 a.m., CNA #3 was observed to lather her hands for 16 seconds prior to rinsing. She was then observed to move a small stool on wheels over to a dining room table with her bare hands. She then was observed to re-wash her hands, lathering her hands for 13 seconds prior to rinsing. She was then observed to sit down next to a resident seated at a dining room table to assist the resident with the lunch meal. At 11:46 a.m., CNA #3 was observed to get up from the table to assist a resident in a wheelchair. She was observed to move to the handwashing sink and lather her hands for 11 seconds prior to rinsing. She was then observed to return to the dining room table where she had been			

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	seated to assist residents with the lunch meal. At 11:53 a.m., CNA #2 was observed to enter the dining room and pick up clean clothing protectors for residents without washing her hands. She was observed to place clean clothing protectors on residents while holding the other clothing protectors between her arm and her uniform. She was then observed to move to the handwashing sink and lather her hands for 16 seconds prior to rinsing. She then sat down at a dining room table to assist residents with their lunch meal. At 11:59 a.m., CNA #2 was observed to stand up from the table where she had been seated by pulling her chair back from the dining room table with her right hand so a dietary person could deliver a resident's food. She was observed to butter the resident's dinner roll without washing her hands. The dinner roll was left on top of the tablecloth and not placed back on the resident's plate. The resident was observed to eat the dinner roll. CNA #2 was then observed to leave the dining room table ,move to the handwashing sink, and lather her hands for 15 seconds prior to rinsing. She was observed to return to the dining room table to feed a resident and assist another resident with the lunch meal.			

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	At 12:10 p.m., CNA #2 was observed to push a resident seated in a wheelchair from the dining room into the hallway. She was observed to re-enter the dining room and lather her hands for 11 seconds prior to rinsing. She was then observed to sit down next to a resident seated at a dining room table by pulling her slacks up with her hands. She then handled a glass of juice for a resident, and picked up the resident's eating utensils to prepare the food for her to eat. At 12:14 p.m., CNA #2 received bowls of food for a resident and began to feed her. She was not observed to wash her hands At 12:23 p.m., CNA #4 was observed to push a resident seated in a wheelchair into the dining room. She was then observed to place a clean clothing protector on the resident without washing her hands. At 12:27 p.m., CNA #3 was observed to enter the dining room and lather her hands for 10 seconds prior to rinsing. She was then observed to to sit next to a resident seated at a dining room table and handle the resident's clean clothing protector.			

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	At 12:30 p.m., CNA #3 was observed to assist the same resident to eat by handling her eating utensils. The Director of Nursing (DON) was interviewed on 8/20/15 at 2:50 p.m. During the interview she indicated clean clothing protectors should not be held up against a staff's uniform, but questioned why staff should have to wash their hands prior to putting a clean clothing protector on a resident. She also indicated she had instructed the CNAs to wash their hands to a quick rendition of the Happy Birthday song, approximately 10-12 seconds. When queried, she indicated staff did not have enough time to stand at the sink and wash their hands for 20 seconds. She further indicated food items in the pantry refrigerator/freezer and the cleanliness of the refrigerator/freezer and the pantry were the responsibility of the Dietary Department. The Certified Dietary Manager (CDM) was interviewed on 8/20/15 at 4:00 p.m. During the interview she indicated the Dietary Department was responsible for stocking the pantry, throwing un-dated and un-labeled items away, and keeping it clean. The CDM was interviewed on 8/21/15 at 1:30 p.m. During the interview she			

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	indicated the 3rd shift in the Dietary Department were to clean the pantry everyday. A current facility policy "Handwashing", revised on 9/06 and provided the CDM on 8/20/15 at 3:03 p.m., indicated "...To minimize the risk of infection to the patient and caregiver. To prevent direct and indirect transfer of micro-organisms from care provider to patient...Moisten hands and apply soap...Wash hands for 20 seconds to one minute as indicated...Hands should be washed...After contact with patient...before handling food...." A current facility policy "Village Pantry", with a revision date of 07/13 and provided by the CDM on 8/20/15 at 3:03 p.m., indicated "...Food items stocked in Village Pantry will be kept safe and sanitary...All foods will be labeled by identification and dated at which date the items are to be thrown out...Refrigerators will be checked for outdated items...." A current facility policy " Handling/Transport/Storage of Clean Linen". with a review date of June 26, 2015 and provided by the DON on 8/21/15 at 10:46 a.m., indicated "...Hand hygiene must be performed immediately before handling clean linen...Always			

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	handles clean linen in a sanitary manner by keeping linen away from clothing & off of possible contaminated surfaces...." 3.1-21(i)(2)			